

Medical Release Authorization

ERD Case Number: _____

Sections 111.35 & 101.22 Wisconsin Statutes allow the Equal Rights Division to secure medical information to investigate a complaint. Completion of this authorization is voluntary. Personal information you provide will not be used for secondary purposes (15.04(1)(m)).

Physician or Medical Facility Name

Physician or Medical Facility Street Address

Physician or Medical Facility City

Physician or Medical Facility State

Physician or Medical Facility Zip Code

I give permission to the above named physician or medical facility to release information regarding my physical and/or mental condition from (date)_____ to (date)_____ to Equal Rights Officer _____. The Equal Rights Officer will use this information to assist in the investigation of my complaint that I filed with the Equal Rights Division of the Department of Workforce Development.

I authorize the physician or medical facility to pre-bill me for the information released to the Equal Rights Division. I have been informed that I may revoke this authorization in writing at any time.

This authorization will be valid for six (6) months from the date signed below.

Name of Patient

Patient Date of Birth

Authorizing Signature

Date Signed

Patient Street Address

Patient City

Patient State

Patient Zip Code

Please mail completed authorization form to the Equal Rights Division address checked below.

☐ PO Box 8928
Madison, WI 53708

☐ 819 N. 6th St., #255
Milwaukee, WI 53203

☐ 1802 Appleton Road
Menasha, WI 54952

☐ 221 W Madison St Ste 218
Eau Claire, WI 54703

☐ PO Box 646
Racine, WI 53401-0646